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# **District of Columbia's Managed Care Quarterly Performance Report**

**(January 2014 – March 2014)**

**Department of Health Care Finance**

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October 2014  
Washington DC

# Presentation Outline

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- Overview Of Managed Care And Focus of Presentation**
- Summary of Key Findings
- The Financial Condition of The District's Health Plans
- The Administrative Performance Of The Health Plans
- MCO Medical Spending And Member Utilization Patterns
- Care Coordination: Goals and Outcomes

# Overview of The District's Managed Care Program

- ❑ Medicaid is the largest health insurance program in the District
  - 235,000 Medicaid beneficiaries (1 in 3 District residents)
  - 93,000 children in the District of Columbia are enrolled in Medicaid
  - Nearly 70% of program beneficiaries are in one of four Managed Care Organizations (MCO)
    - ❖ AmeriHealth DC (AmeriHealth)
    - ❖ MedStar Family Choice (MedStar)
    - ❖ Trusted Health Plan (Trusted)
    - ❖ Health Services for Children With Special Needs (HSCSN)
- ❑ Three of these health plans offer comprehensive benefits and operate under full risk-based contracts with the District
- ❑ The District will spend more than \$912.1 million on MCO services on FY2014
- ❑ More than \$763.6 million of this amount will be for the full risk-based contracts signed by AmeriHealth DC, MedStar Family Choice, and Trusted
  - ❖ These plans are the focus of this performance review

# Overview of The District's Managed Care Program (continued)

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- ❑ The District also funds managed health care services for the Alliance program which offers health care to District residents who would be eligible for Medicaid but for their citizenship status
- ❑ Alliance has more than 14,000 members who are enrolled in the District's three full risk-based MCOs
- ❑ Benefits offered through the Alliance program are virtually identical to those provided in Medicaid but do not include non-emergency transportation or mental health services
- ❑ In FY2014, the District is projected to spend approximately \$38 million on the Alliance program

# Goals Of The District's Managed Care Program

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- ❑ The District developed its MCO program in pursuit of three broad goals:
  1. Increase access to a full range of primary, clinic-based, hospital, mental health, and specialty care services for managed care members
  2. Ensure the proper management and coordination of care as a means of improving beneficiaries' health outcomes while promoting efficiency in the utilization of services
  3. Establish greater control and predictability over the District's spending on health care

# Medicaid Rate-Setting For Health Plans Governed By Federal Requirements

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- ❑ For the full risk-based MCOs, the Department of Health Care Finance (DHCF) pays a capitated, per-member, per-month (PMPM) rate
  - The capitated rate is a set amount to cover projected costs for all benefits
- ❑ Medicaid federal regulations impose specific requirements to govern rate-setting
  - Rates must be actuarially sound, developed by a credentialed actuary and certified by CMS
  - Rates must be appropriate for covered populations and benefit package
  - Uncertified rates are not eligible for federal match
- ❑ Alliance program does not need federal approval
  - Actuarial soundness rule for this program is a District contract requirement
- ❑ DHCF contracts with Mercer Consulting to establish the actuarially sound rates for the program and assist with data analytics on measuring MCO program performance

# Key Program Requirements Faced By The District's Health Plans

Program Area	Requirement	Source
Network Adequacy	The District must ensure that each MCO maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract. The network of providers must be sufficient in number, service mix (e.g. primary care, specialty care, dental etc.) and geographic distribution to meet the needs of the anticipated number of enrollees in the health plans.	Federal Requirement and District Contract
Member Choice of Plan	Beneficiaries who are required to enroll in managed care must be given a choice among at least two plans.	Federal Regulation
Navigation Support For Enrollees	The District must ensure that all services covered under the State plan are available and accessible to enrollees of the plans. Each MCO must maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.	Federal Regulation
Health Assessments	Health plans must assess each Medicaid enrollee identified by the District and the MCO as having special health care needs. The purpose of the assessment is to ascertain any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. In addition, the District's Enrollment Broker must complete a health assessment for every newly eligible enrollee. The information is submitted to the respective health plan to which the member is assigned for use in establishing an initial plan of care for the enrollee as needed.	Federal Requirement and District Contract

# Key Program Requirements Faced By The District's Health Plans (continued)

Program Area	Requirement	Source
Out-of-Network Care	Health plans must afford enrollees the opportunity to seek a second medical opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain a second opinion from outside the network, at no cost to the enrollee. If the health plan's network is unable to provide necessary services covered under the contract, the MCO must adequately and, in a timely manner, cover these services out-of-network for the enrollee.	Federal Requirement
Medical Loss Ratio	The District requires its health plans to meet a medical loss ratio (MLR) which requires that they spend at least 85 cents of every premium dollar on medical care. The health plans must report their premium dollar expenditures to DHCF to facilitate an independent assessment of whether this requirement is met. Plans that do not reach this 85% threshold face a number of possible actions, including monetary penalties assessed by DHCF	District Contract
Risk-Based Capital	Risk-based Capital (RBC) is a widely used financial metric to measure the solvency of managed care plans. The District's insurance regulator requires plans to maintain assets equal to 200% of their RBC. Under District law, DISB has the authority to initiate preventive and corrective measures that vary depending on the capital deficiency indicated by the RBC review. DHCF revised the managed care contracts to indicate that the agency will freeze enrollments for any health plans with a RBC level of 150 or less	District Regulation

# DHCF Implements A Performance Review Of Its Managed Care Program

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- ❑ To coincide with the new five-year MCO contracts, DHCF initiated a comprehensive review process in FY2014 to assess and evaluate the performance of its health plans
  
- ❑ The goal of this project is three-fold:
  1. Evaluate the degree to which DHCF's three risk-based health plans successfully ensure beneficiary access to an adequate network of providers while managing the appropriate utilization of health care services
  2. Provide objective data on the performance of the health plans across a number of domains to inform decision making about possible policy changes for the managed care program
  3. Facilitate an annual report card evaluation of each MCO to help guide decisions regarding contract renewals for the health plans

# Focus Of The Performance Review

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- ❑ The MCO performance review is conducted quarterly. This report focuses on the period from January to March 2014 with some information reported as late as June 2014. The following questions are addressed for each MCO:
  - What is the financial health of the MCOs including the risk profile of the plans? Are plan revenues sufficient to cover claims and operating cost?
  - What is the demonstrated ability of the MCOs to meet the administrative requirements for plan management – claims processing, development of encounter systems, and establishing an effective care management program?
  - What are the trends in MCO medical spending across the various health care service categories?

# Focus Of The Performance Review (continued)

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- What are the observed trends in the rate at which Medicaid beneficiaries use the emergency room for low acuity or non-emergency health problems? What proportion of these visits should the health plans be reasonably expected to prevent?
- What proportion of inpatient hospital admissions for Medicaid beneficiaries over the past nine months were potentially avoidable? What proportion of these potentially avoidable admissions should the health plans be reasonably expected to prevent.
- Are hospital readmissions a problem for the health plans? If so, what proportion of readmissions can the MCOs be expected to prevent?

# Annual MCO Performance Report Schedule For 2014

Nature of Report	Review Period	Report Date
1 <sup>st</sup> Quarter Performance Review	July 2013 to September 2013	February 2014
2 <sup>nd</sup> Quarter Performance Review	October 2013 to December 2013	June 2014
3 <sup>rd</sup> Quarter Performance Review	January 2014 to March 2014	October 2014
4th Quarter Performance Review	April 2014 to June 2014	December 2014
Annual Report Card (4 Quarter Roll-Up)	July 2013 to June 2014	December 2014

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# Summary Of Key Findings

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- ❑ As with previous reports, this quarterly performance review examined the financial condition, administrative performance, case management activities, and the medical spending of the District's three full risk based health plans.

## Financial Conditions

- ❑ The financial condition of the health plans reveals no cause for serious concern. Two of the three plans finished the quarter in a positive revenue situation while all three enjoy sufficient liquidity to cover expenses for a significant number of days without having to use long-term assets.
- ❑ Based on a quarterly estimate, the Risk-Based Capital (RBC) positions of the health plans are above the levels that would trigger any regulatory action by DHCF. However, only MedStar possessed a quarterly RBC level that would meet the desired level of 200% and avoid the requirement of developing an action plan to achieve the required threshold.

# Summary Of Key Findings

(continued)

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## Administrative Performance

- ❑ While the health plans have struggled to pay dental claims at a recently imposed and higher rate funded by DHCF, there are no systematic administrative problems plaguing health plan operations. For the key administrative metrics -- provider network adequacy, reasonable administrative spending, timely payment of claims through an adjudication process using remittance advices, and development of robust and accurate encounter data systems – the three health plans continue to perform quite effectively.

## Case Management

- ❑ The health plans are making greater efforts to assess a larger share of their membership for case management services, especially AmeriHealth, which has reached out to 25 percent of its membership. Still, the percentage of MCO members who both require and agree to participate in case management remains small, especially for Trusted.

# Summary Of Key Findings

(continued)

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## Medical Expenses

- ❑ All three health plans continue to meet or come close to the 85% Medical Loss Ratio - the threshold requirement for spending on health care services. Nonetheless, significant differences remain in the per-member-per-month membership medical cost experienced across the three plans that cannot be readily explained by differences in the beneficiaries' health profiles.
- ❑ DHCF's new policy to risk adjust rates was implemented in May 2014 and will be refined in November 2014. Because of this new policy, close attention is being paid to the relative differences in beneficiary risk experienced by the three plans and the associated medical expenses for each MCO. Any health plans that have low member low risk scores but high beneficiary medical costs will be in an unenviable position. Such a scenario could speak to difficulties in coordinating patient care as a means of controlling cost or, the payment of higher provider contract rates. Whatever the reason, this situation will not be sustainable over a significant period of time.

# Summary Of Key Findings

(continued)

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## Medical Expenses (continued)

- ❑ We continue to track the primary care visit rates for both adults and children as the desired gateway to appropriate and efficiently delivered health care. The primary care visit rates for both groups remain high; however, as increasing numbers of adults reach 12 months of continuous participation in the program, we are seeing a slight deterioration in their primary care visit rate. This is not true for children.
- ❑ This third quarter report does reveal increased spending on mental health services -- especially for children -- by all three health plans. Moreover, in October 2014, DHCF rolled out its program to expand and better document primary and diagnostic care for children as a means of improving care management activities for those who have diagnosed specific health care needs. The first group of children who will benefit from this program are those who are served in the fee-for-service environment. In three months, this program will be extended to the nearly 100,000 children in managed care.

# Summary Of Key Findings

(continued)

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## Care Coordination

- ❑ With three quarters of data for each of the health plans, we now possess sufficient information to support a more detailed analysis of the progress MCOs are making with efforts to better coordinate their members' care. More sophisticated measures have been constructed to track low acuity hospital admissions, readmission rates for persons being treated for the same illness, and the use of the emergency room for routine care.
  
- ❑ The rate at which beneficiaries continue to use the emergency room for routine care remains high -- from 63 to 72 percent of all visits to the emergency department. Based on Mercer's analysis, the health plans should be expected to prevent from 16 to roughly 20 percent of these visits. The failure of the plans to do so created \$5.9 million in additional cost for the MCOs.

# Summary Of Key Findings

(continued)

## Care Coordination (continued)

- ❑ Analysis of claims data reveal that collectively our MCOs spent an additional \$10.7 million on all-cause 30-day inpatient hospital readmissions. Evidenced based research suggest that a significant proportion -- in some studies over 50% - of these readmissions are preventable.
- ❑ On average our health plans are paying for one hospital readmission for every 12 “index hospital admissions.” These readmissions occur within 30 days of a previous discharge and for the same basic health complaint which triggered the initial admission.
- ❑ Combined these problems -- emergency room use for low acuity illnesses , and potentially avoidable hospital admissions and readmissions -- cost the Medicaid program more than \$22 million in the nine months of the first MCO contract year.

Note: MedPac (2005) estimates that about 75% of readmissions are potentially preventable. Also roughly 90 percent of re-hospitalizations within 30 days after discharge appeared to be unplanned (Jencks, Williams, and Coleman 2009). Also, the \$22 million estimate might be slightly overstated to the extent that any avoidable admissions also capture some hospital readmissions.

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# DHCF's Oversight Of Managed Care Plans' Includes A Close Look At Their Financial Health

- ❑ Quarterly assessments of MCOs' financial health is designed to determine whether the health plans meet financial net worth requirements or are trending towards financial deterioration
  
- ❑ Two key measures are used to evaluate the MCOs' financial conditions
  1. The MCOs' net revenue gain or loss which is determined by subtracting claims expenses from health plan revenue, excluding investment income
  
  2. A risk-based capital ratio is reported in the health plans' annual financial statements and used in this report. In addition, a proxy measure is calculated by the District's actuary and reported on a quarterly basis reflecting the health plans' total adjusted capital levels as a percent of the health plans' authorized control levels. This provides DHCF with information to gauge changes in the health plans' financial condition between annual filings with DISB

# Most of The Membership Growth Since July 2013 Resides With MedStar And AmeriHealth

MCO	July 2013 Enrollment	March 2014 Enrollment	Net Change
AmeriHealth	98,019	106,946	8,927 (9%)
MedStar	35,911	40,034	4123 (11%)
Trusted	28,803	29,746	943 (3%)

Source: Department of Health Care Finance Medicaid Management Information System (MMIS)

# The Quarterly Revenue For Two Of The Three Health Plans Was Sufficient To Cover Both Claims And Administrative Cost During The Quarter

MCO Revenue and Expense Data for January to March 2014

$$\boxed{\text{Revenue}^*} - \boxed{\text{Claims}^{**}} - \boxed{\text{Administrative Cost}^{***}} = \text{Net Gain (Loss)}$$

MCO	Revenue	Claims	Administrative Cost	Net Gain (Loss)
AmeriHealth	\$102.5M	\$83.3M	****\$19.9M	(\$0.7M)
MedStar	\$37.0M	\$31.5M	\$3.7M	\$1.8M
Trusted	\$25.4M	\$20.8M	\$2.9M	\$1.7M

Notes: \*MCO revenue does not include investment income.  
 \*\*Total claims include incurred but not reported amounts for YTD as of March 2014.  
 \*\*\*Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings.  
 \*\*\*\*This estimate overstates AmeriHealth administrative spending as it includes case management cost which should have been reported as a medical expense. This actual figure could be as low as \$13 million. This adjustment will be made in future reports.  
 Source: MCO Quarterly Statement filed by the health plans with the Department of Insurance, Securities, and Banking (DISB)

# Estimated Risk-Based Capital Measures Provide A Reliable Indicator Of MCO Solvency

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- ❑ The MCO's Risk-based Capital (RBC) levels can be seen as a proxy for whether a health plan has the assets to pay claims
- ❑ MCOs conduct this complicated calculation annually for each health plan using end-of-year financial data (as well as some information that is not publically disclosed) which is provided to the Department of Insurance, Securities and Banking (DISB) for review
- ❑ Health plans with RBC levels that fall below 200% face greater scrutiny from DISB (as described on the next slide) to ensure that they raise their capital level above 200% RBC
- ❑ This report compares the annual RBC measure reported by the plans in their official 2013 financial statement filed with DISB to a more recent proxy quarterly measure for the 1<sup>st</sup> Quarter of 2014, calculated by Mercer Consulting

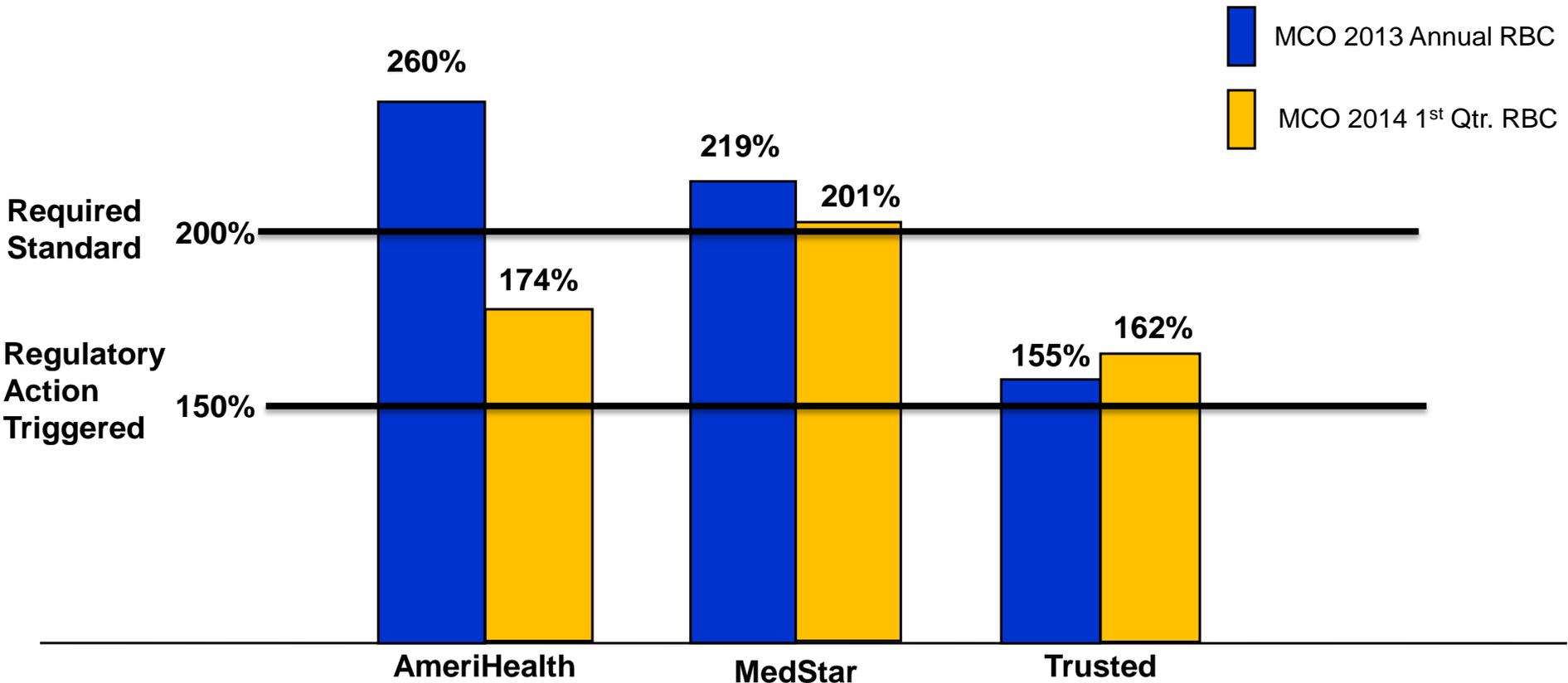
# Insurance Regulators Track Insurers Risk-Based Capital Levels And Have Guidelines For Taking Action

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- ❑ Based on the level of reported risk, the National Association of Insurance Commissioners indicates that a number of actions (described below) are available if warranted:
  1. **No action** - Total Adjusted Capital of 200% or more of Authorized Control Level.
  2. **Company Action Level** - Total Adjusted Capital of 150% to 200% of Authorized Control Level. Insurer must prepare a report to the regulator outlining a comprehensive financial plan that identifies the conditions that contributed to the company's financial condition and a corrective action plan.
  3. **Regulatory Action Level** - Total Adjusted Capital of 100 to 150% of Authorized Control Level. Company is required to file an action plan and the Insurance Commissioner issues appropriate corrective orders to address the company's financial problems
  4. **Authorized Control Level** - Total Adjusted Capital 70 to 100% of the Authorized Control Level triggers an action in which the regulator takes control of the insurer even though the insurer may technically be solvent.
  5. **Mandatory Control Level** - Total Adjusted Capital of less than 70% triggers a Mandatory Control Level that requires the regulator to take steps to place the insurer under control. Most companies that trigger this action level are technically insolvent (liabilities exceed assets).

# The 2014 Estimated 1<sup>st</sup> Quarter RBC Levels For AmeriHealth and MedStar Are Lower Than The Previous Year's Annual Measure But There Is No Cause For Concern. Trusted's Financial Condition Appears To Have Improved

Risk-Based Capital Levels For Managed Care Plans, 2013



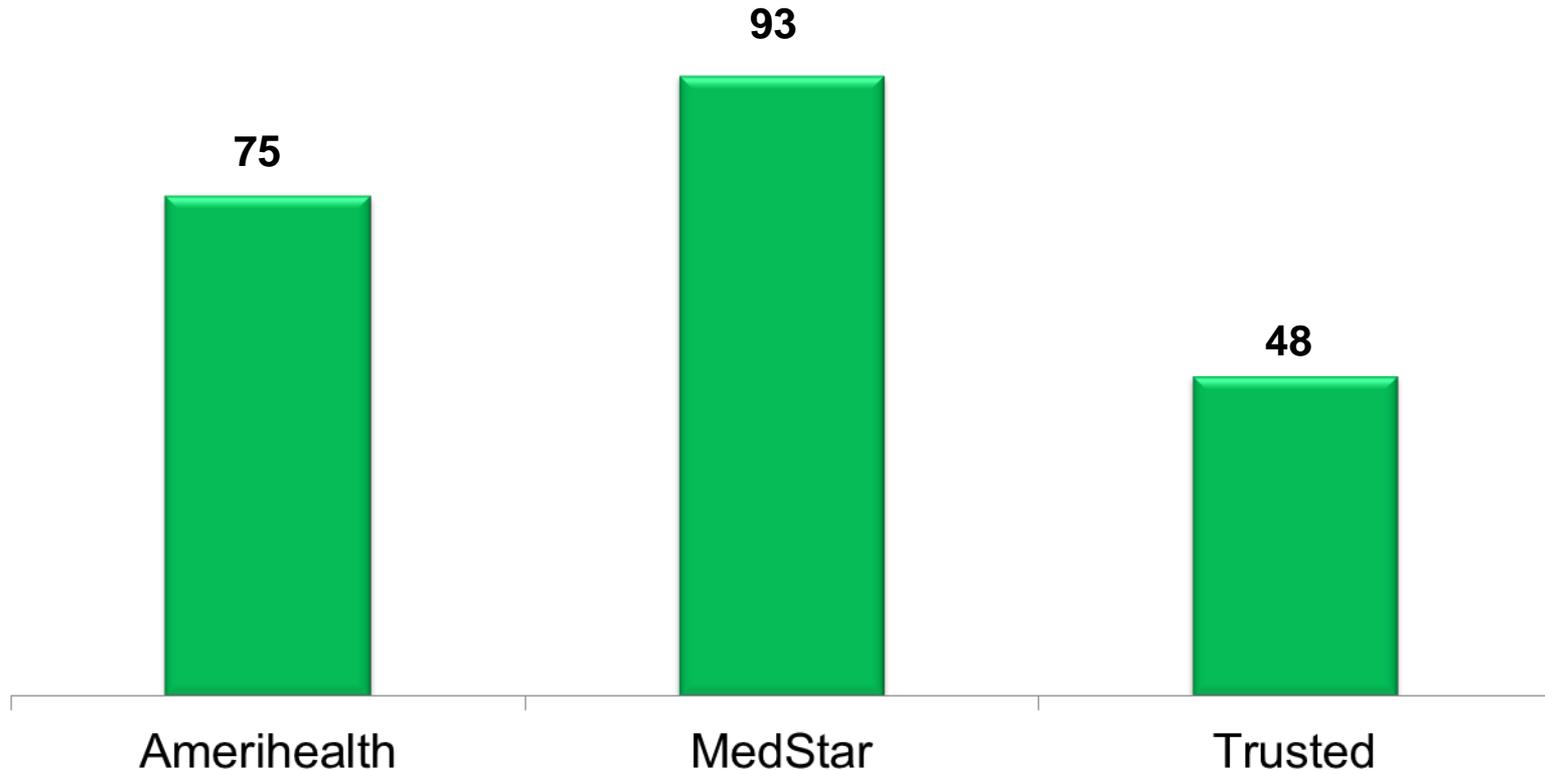
Note: Reported figures are from MCO's annual 2013 financial statement filed with DISB and Mercer's quarterly proxy measure for the first quarter of 2014. MedStar's data for Total Adjusted Capital and Authorized Control Level used in Mercer's calculation of the health plan's RBC level, include information from Maryland and the District of Columbia.

# MCOs Must Maintain Adequate Reserves To Pay “Pipeline” Claims

- ❑ It is paramount in managed care that MCOs maintain a reserve to pay for services that have been provided but not yet reimbursed
- ❑ This claims liability represents an accrued expense or short-term liability for the MCOs each month and health plans that fail to build a sufficient reserve may not be able to pay claims when they eventually clear the billing pipeline
- ❑ Typically, MCOs are expected to retain a reserve equal to between one to two months' worth of claims, depending on how quickly claims are processed.
- ❑ In future reports DHCF will track the reserves MCO's have available to satisfy incurred but not reported claims. This analysis will be based on calculations provided by Mercer who will rely upon data on the monthly claim's experience for each plan to calculate the reserves on hand
- ❑ In this report, an analysis is conducted of the number of days the health plans can operate without accessing long-term assets. This is described as a Defensive Interval Ratio which is, in essence, a liquidity measure -- the degree to which the MCOs can survive on liquid assets without having to make use of either investments from the market or by selling long term assets. This measure will be tracked over time, as well, in future reports

# The Defensive Interval Ratio – Which Compares MCO Assets To Company Liabilities – Is Favorable For All Three Health Plans

Days In A Quarter That MCOs Can Operate On Existing Cash Without Having To Access Long-Term Assets



Note: Mercer calculated the Defensive Interval Ratio as cash and equivalents divided by daily operating expenses for the quarter defined as 91.2 days.

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# There Are Several Administrative Requirements Which Are Critical To The Successful Operation Of MCOs

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- ❑ As a part of its core mission, MCOs must accomplish the following:
  1. Build an adequate network of providers and pay health care claims to service providers on time and through an electronic claims process with documentation to facilitate reconciliation of payments
  2. Create an accurate electronic record of all patient health care encounters and transmit the files containing this information to DHCF with a minimal error rate
  3. Establish a system of care management and care coordination to identify health plan members with special or chronic health care issues and ensure that these beneficiaries receive access to appropriate care, while managing the delivery of health care services for all members

# Contractual Requirements Exist To Ensure Adequate Health Care Provider Networks

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- ❑ The five-year MCO contracts contain specific provisions to ensure Medicaid and Alliance members have reasonable access to care. The health plans must have:
  - 1 primary care physician for every 1,500 members
  - 1 primary care physician with pediatric training for children through age 20 for every 1,000 members
  - 1 dentist for every 750 children in their networks
  
- ❑ Additionally plan networks must include:
  - At least 2 hospitals that specialize in pediatric care
  - Department of Behavioral Health core service agencies
  - Laboratories within 30 minutes travel time from the member's residence
  
- ❑ For pharmacies, each plan must have:
  - 2 pharmacies within 2 miles of the member's residence
  - 1 24-hour, seven (7) day per week pharmacy
  - 1 pharmacy that provides home delivery service within 4 hours
  - 1 mail order pharmacy

# All Three Health Plans Have Impaneled Substantially More Physicians Than Required By Contract Standards

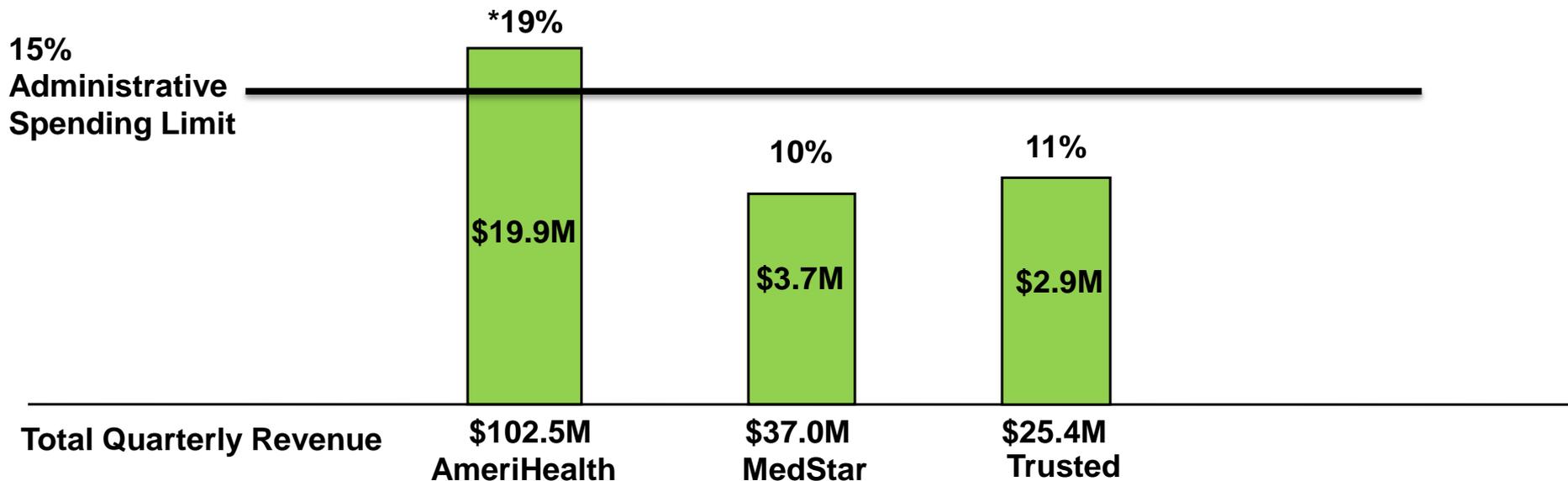
Providers In The MCO Networks Compared to Contract Requirements as of June 2014

Health Plan	Primary Care Doctors Required In Network (1:1500)	Primary Care Doctors In The MCO Network	Primary Care Doctors With Pediatric Specialty Required In Network (1:1000)	Doctors With Pediatric Specialty In Network	Dentist For Children Required In Network (1:750)	Dentist For Children In Network
DC AmeriHealth	73	<b>532</b>	54	<b>832</b>	72	<b>237</b>
MedStar FP	27	<b>513</b>	14	<b>368</b>	19	<b>500</b>
Trusted	20	<b>481</b>	10	<b>270</b>	14	<b>236</b>

Source: This information is self-reported and attested by the MCOs as of June 30, 2014 and verified by Department of Health Care Finance and the Enrollment Broker through a sampling of providers.

# There Are No Reasons For Concern Regarding MCO Administrative Cost

## Quarterly Administrative Spending For MCOs As A Percent Of Total Revenue, January 2014 to March 2014

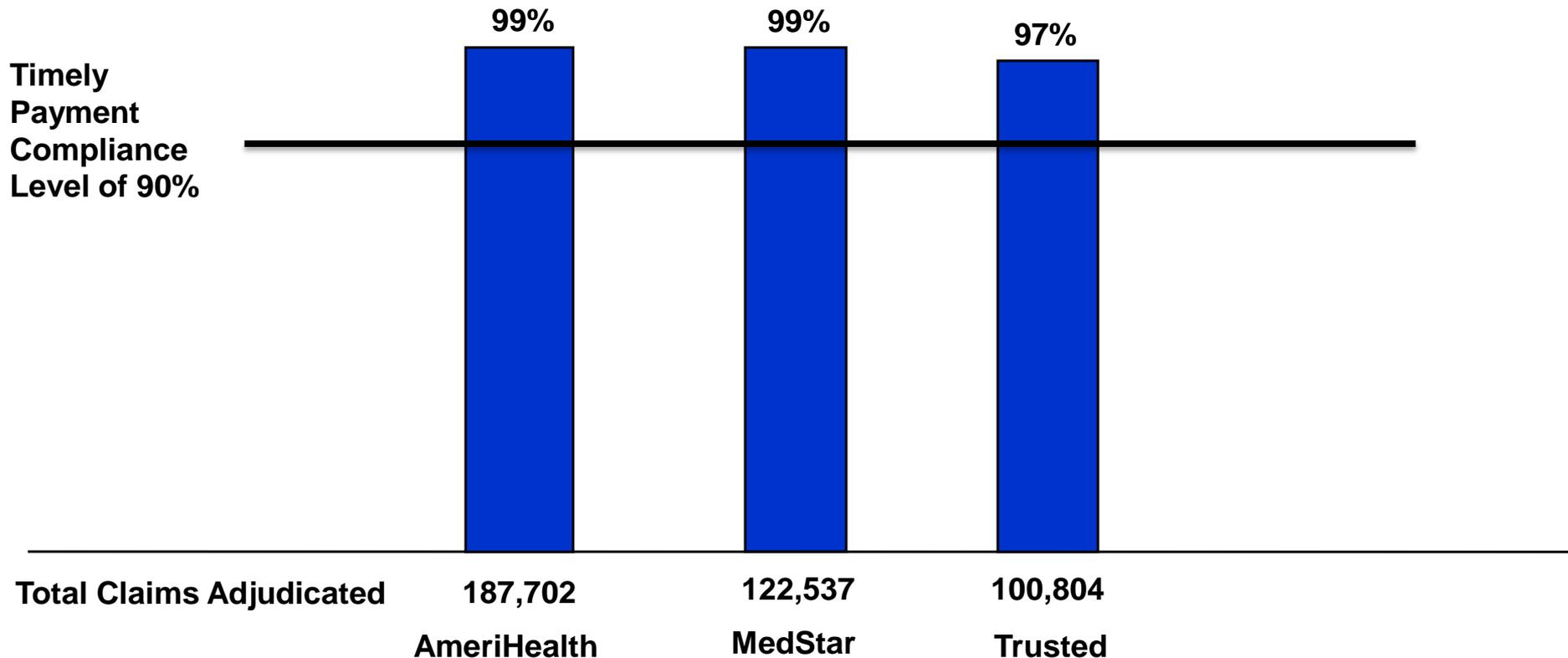


Note: This calculation of administrative cost is not adjusted for the Health Insurance Provider Fee, DC Premium/ exchange taxes and cost containment expenses, the latter of which some plans have incorrectly reported as administrative expenses. With these adjustments, are accounted for, AmeriHealth's administrative costs decreases to about 13%. These adjustments will be made in future reports.

Source: Total administrative expenses including all claim adjusted expenses as reported in quarterly DISB filings

# The Health Plans' Performance With Respect To Timely Payment Of Claims Remained High Through The 2<sup>nd</sup> Quarter Of 2014

## MCO Claims Paid Within 30 Days Based On The District's Timely Payment Requirement



# DHCF Adjusted Dental Payments To Ensure Patient Access To Care

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- ❑ Due to growing concerns of low dental reimbursement rates by the health plans, DHCF and Mercer reviewed past utilization data submitted by DentaQuest and determined that the rates offered by the health plans were significantly below the rates paid within the District's fee-for-service (FFS) Medicaid program.
- ❑ DHCF increased the health plans overall capitation rates, requiring each to adjust its dental fee schedule (children and adults) to no less than 80% of the District's dental FFS fee schedule, retroactive to May 1, 2014 and on through April 30, 2015.
- ❑ DentaQuest began to implement the rate increase in July. Due to reported limitations with configurations of its claims systems, DentaQuest planned to void existing claims and require providers to resubmit claims that were previously paid at the lower rates for dates of service May 1, 2014 – July 1, 2014.

# However This Adjustment Has Created Administrative Difficulties And Payments Are Not Correct

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- ❑ Although dental claims were resubmitted, due to a number of systems problems, the claims were not consistently paid at the higher rates
  - ❖ New or resubmitted claims were missing from DentaQuest's claims system.
  - ❖ New or resubmitted claims were denied by the system as duplicate claims for the same dates of service
- ❑ While dental claims are being paid within 90 days as required by District law, Dentaquest's system problems have resulted in inaccurate payments to providers
- ❑ MCOs are developing an action plan with DentaQuest that outlines the disbursement of payments to affected providers
- ❑ DHCF will monitor this situation to confirm completion of payments within the required timelines

# The Health Plans Have Successfully Constructed Encounter Data Files But Should Continue To Improve The Accuracy Rate For The Data Transfers

Number of Recorded Encounters And Accuracy Transfer Rate, July 2013-March 2014

MCO	Average Monthly Enrollment	Total Encounters	Total Encounters Per Enrollee	Accuracy Rate For Encounter Transfers
AmeriHealth	105,867	1,289,189	12.1	83%
MedStar	38,727	416,106	10.7	93%
Trusted	28,900	254,445	8.8	82%

Source: Department of Health Care Finance Medicaid Management Information System as of June 2014

# The Health Plans' Case Management Systems Are Maturing But The MCOs Still Have More Work To Do

Health Plan	Average Monthly Enrollment	Health Staff Working Case Management	Number of Members Assessed For Case Management	Members In Case Management
DC AmeriHealth	102,342	43	25,655 (25.0%)	<b>3,225</b> <b>(12.5%)</b>
MedStar FP	35,027	22	2,138 (6.1%)	467 (21.8%)
Trusted	26,813	12	3,614 (13.4%)	<b>344</b> <b>(9.5%)</b>

Source: This information is self reported by the MCOs as of September 2014

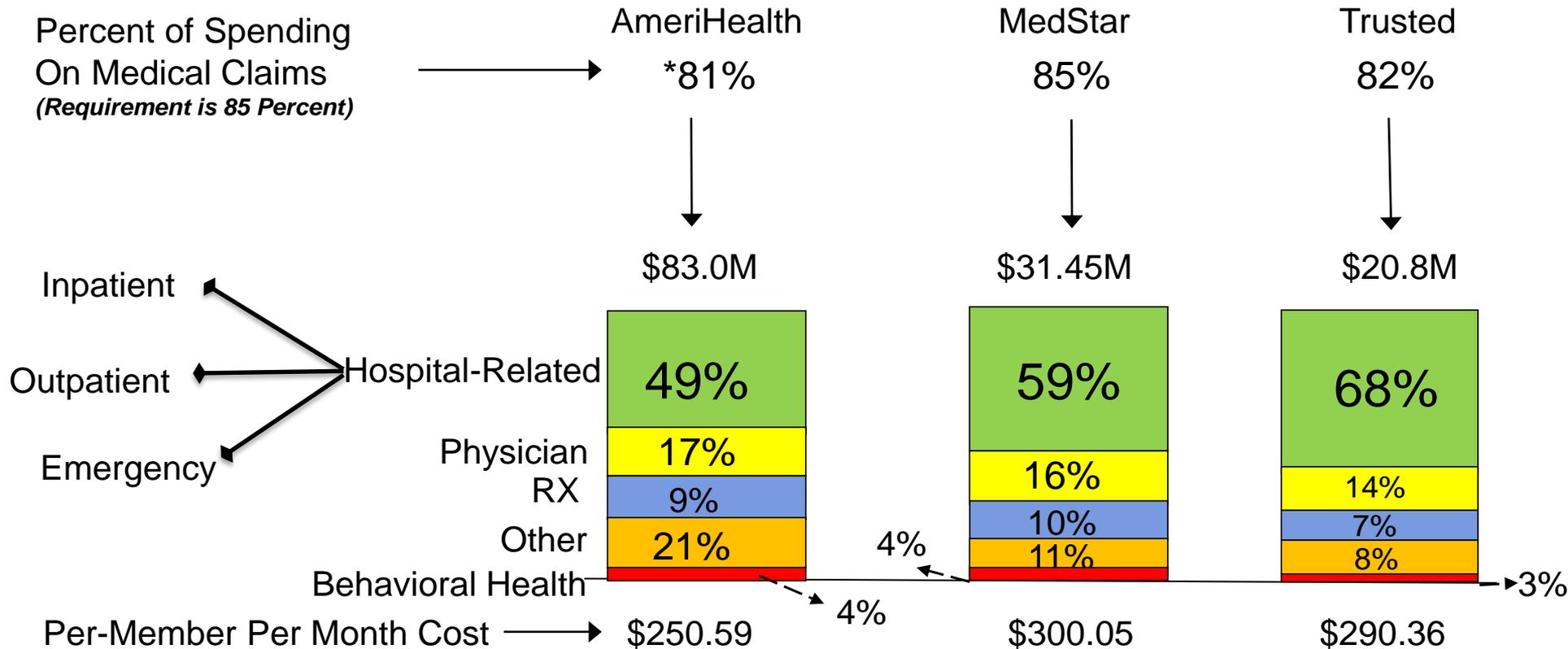
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# In The 3<sup>rd</sup> Quarter Of The Contract Year, MCO Spending On Medical Services Reveal No Appreciable Shifts With The Exception Of Higher Observed Hospital-Related Cost For Trusted

## MCO Medical Spending In Major Health Care Service Categories, January-March 2014

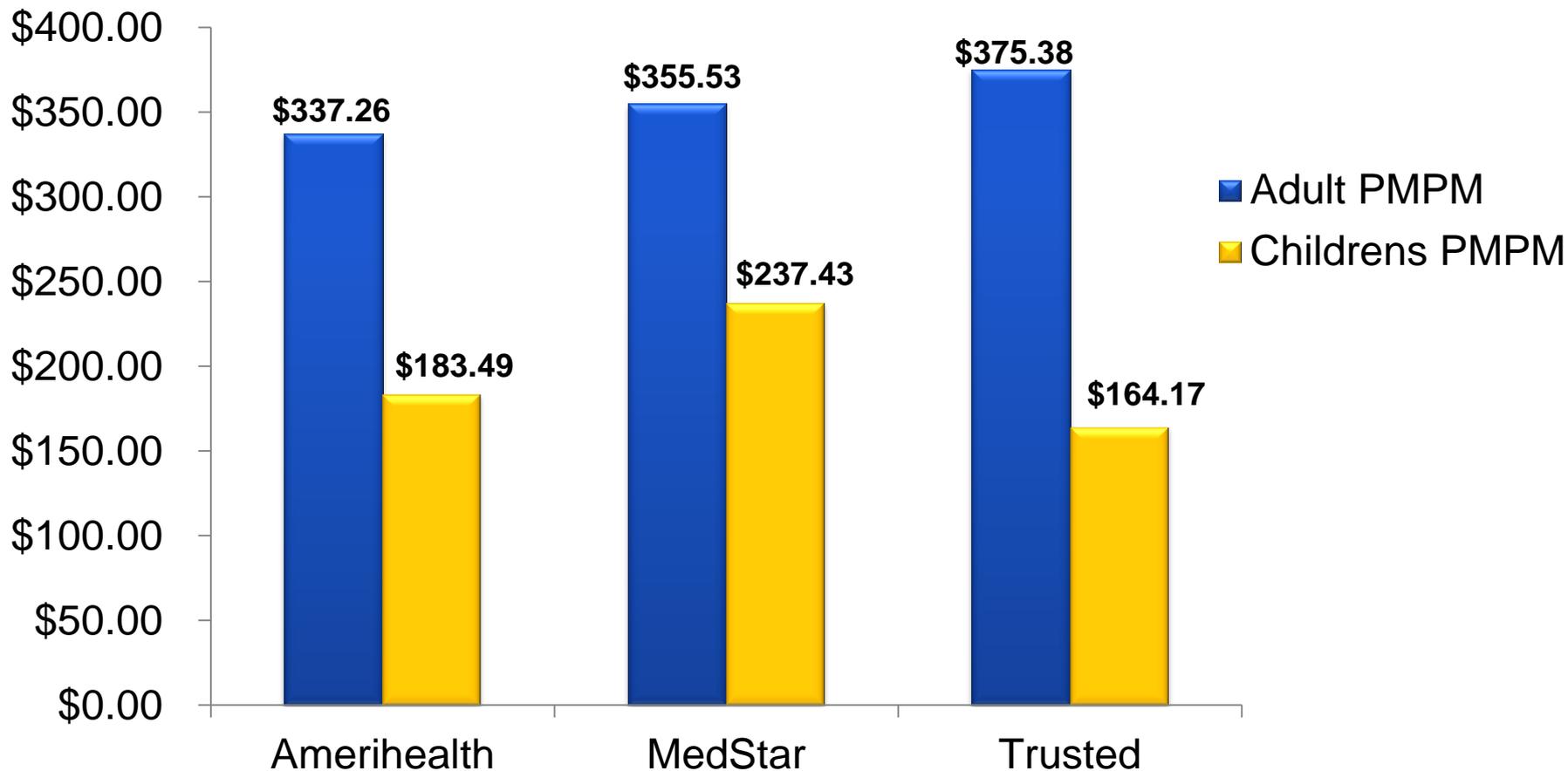


Note: Hospital-related costs consist of the following : AmeriHealth (Inpatient 31%, Outpatient 7%, ED 11%); MedStar (Inpatient 43%, Outpatient 9%, ED 7%); and Trusted (Inpatient 28%, Outpatient 17%, and ED 23%). PMPM amounts are based on total reported claims expenses occurred from July 2013 through March 2014 expense, including estimates for IBNR (Incurred But Not Reported) claims which Mercer conducts based on payment patterns observed in the lag data through May 2014.

\*This number may be as high as 87% based on a re-categorization of AmeriHealth's administrative and medical expenses.

# Nonetheless The Across Plan Differences In Medical Cost After Nine Months Bear Watching As We Approach The Implementation Of Risk Adjusted Rates

MCO Adult And Children Medical Expenses Per-Member, Per-Month, July 2013 through March, 2014



Notes: Expenses incurred from July 1, 2013 to March 31, 2014 and paid as of May 31, 2014. The expenses do not reflect adjustments to account for INBR claims. Children defined as person up to age 21 in this analysis.

Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

# The Health Plans That Are Unable To Align Beneficiary Medical Costs With Assigned Risk Scores Face Future Challenges

## Ranking On Risk Scores For Adjusting Future Rates

		Low	Medium	High
Ranking On Medical Cost	Low	Trusted - Children		AmeriHealth -- Adults
	Medium		MedStar -- Adults	AmeriHealth -- Children
	High	Trusted -- Adults	MedStar -- Children	

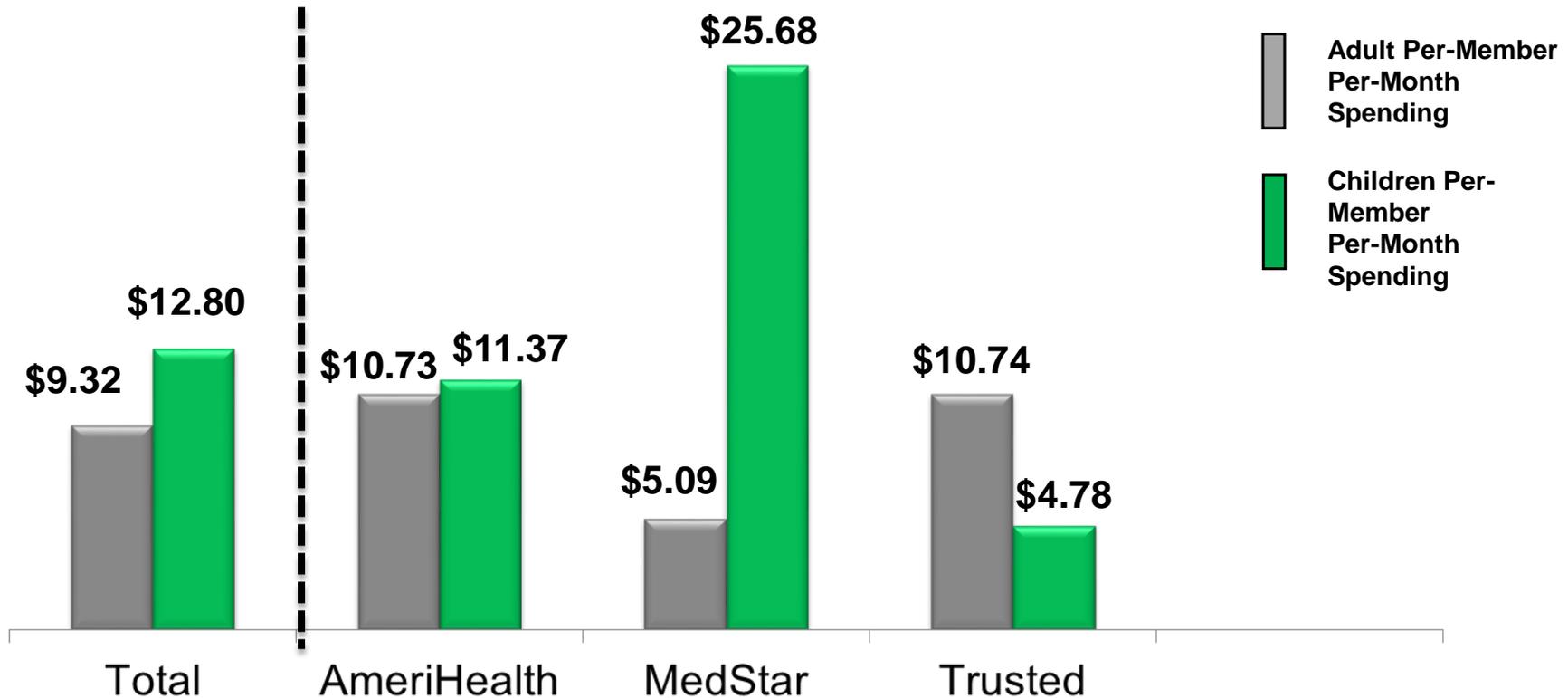
Notes: Expenses incurred from July 1, 2013 to March 31, 2014 and paid as of May 31, 2014. The expenses do not reflect adjustments to account for INBR claims.

Children defined as person up to age 21 in this analysis. Health plans' risk scores are derived from pharmacy data.

Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

# Mental Health Spending On Children And Adults -- Once as Low As \$6.00 Per Member Per Month -- Has Increased Considerably As Of March 31, 2014

The Per-Member Per-Month MCO Expenses For Behavioral Health Services, July 1, 2013 to March 31, 2014

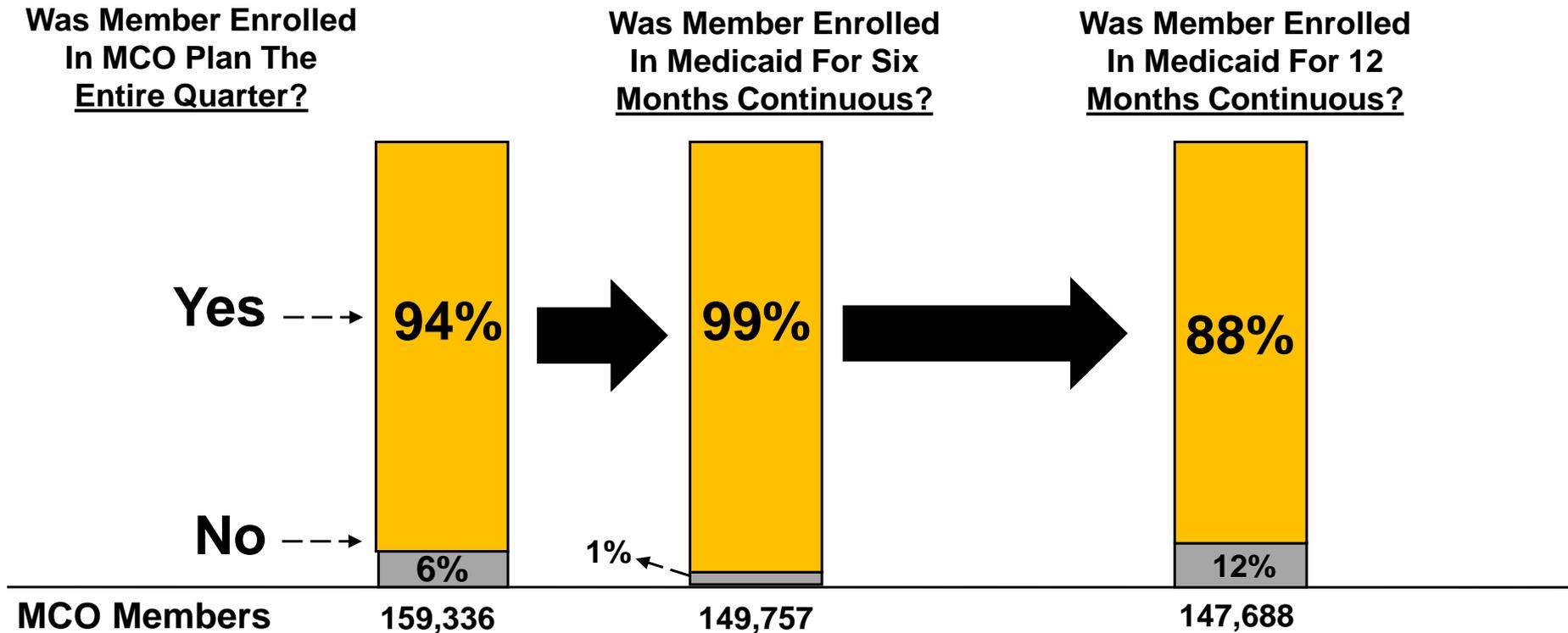


Notes: Expenses incurred from July 1, 2013 to March 31, 2014 and paid as of May 31, 2014. The expenses do not reflect adjustments to account for INBR claims. Children defined as person up to age 21 in this analysis.

Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

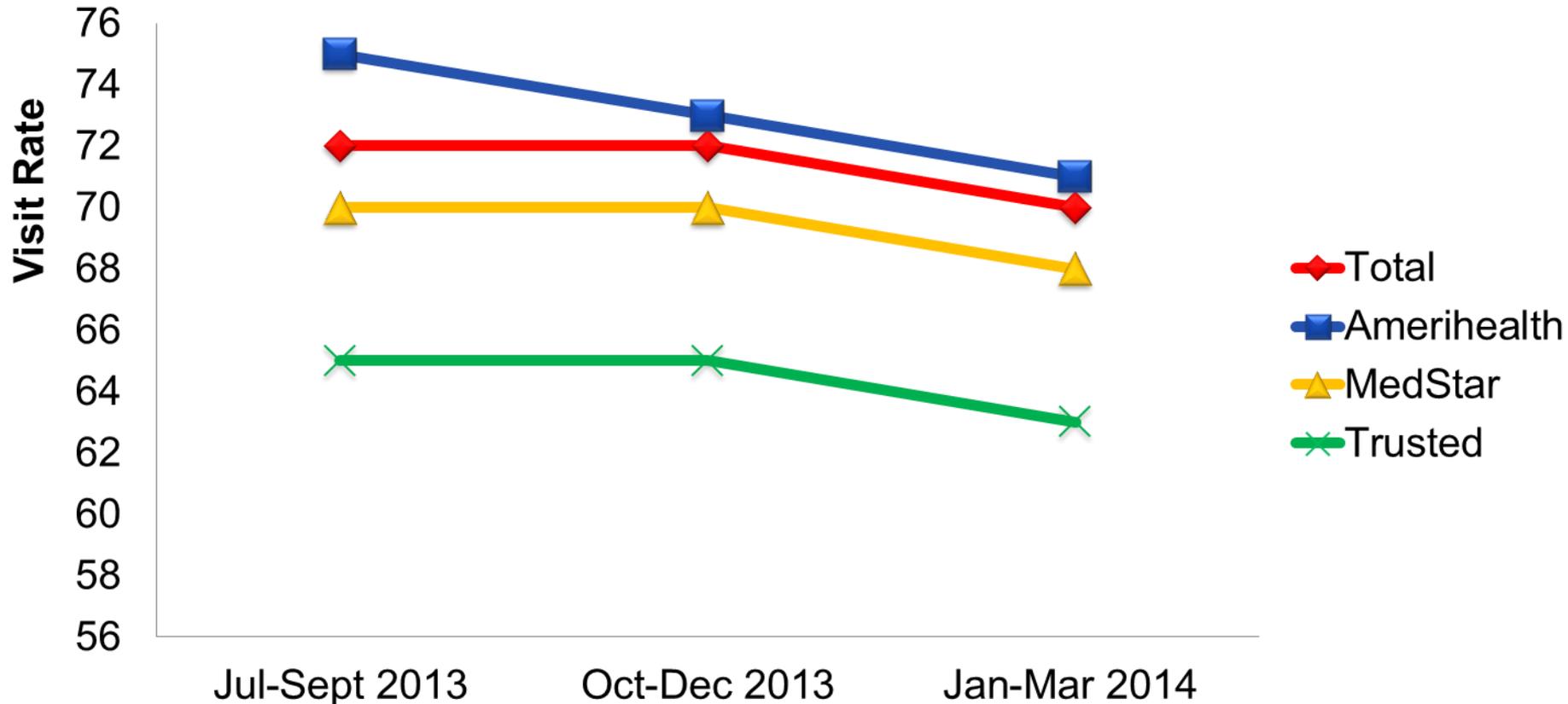
# The Amount Of Movement In And Out Of The Three Health Plans Continues To Be Minimal While The Proportion Of Members With 12 Months Of Continuous Medicaid Enrollment Remains High

Eligibility And Plan Membership Patterns For Beneficiaries Who Were Enrolled In Managed Care During The Period Of January 1, 2014 Through March 31, 2014



# The Primary Care Visit Rate For Adults Is Around Seventy Percent But Beginning To Trend Slightly Downward

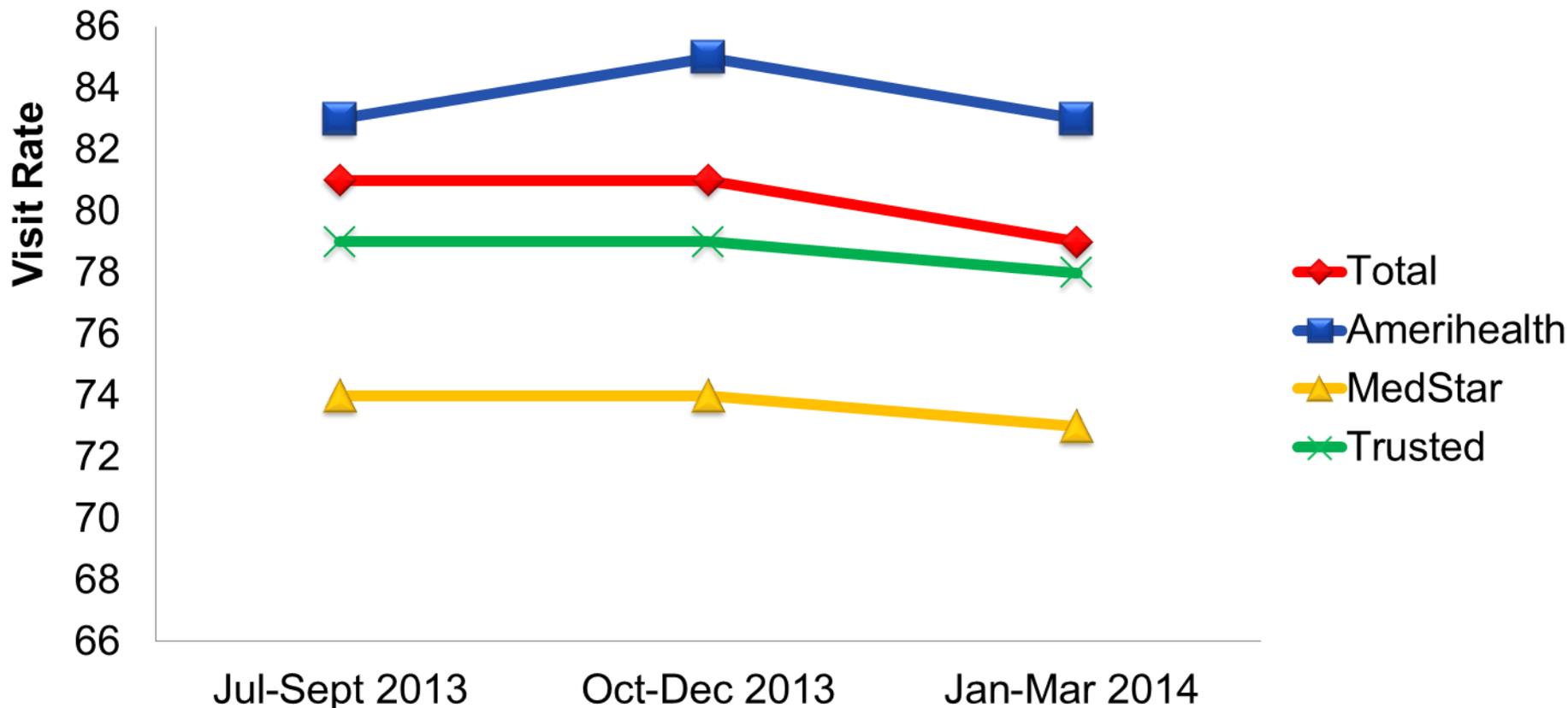
Primary Care Visit Rates For Adults Who Were Enrolled In Managed Care During The Period Of January 1, 2014 Through March 31, 2014 And Had 12 Months Of Continuous Eligibility



Note: Only members who were enrolled with the health plan for three months continuously during the period of January 2014 through March 2014 and had 12 months of continuous Medicaid participation as of March 31 2014 are included in this analysis. Dates of service for primary care visit are March 2013 through March through 2014.

# For Children, The Overall And Within MCO Primary Care Visit Rates Are Consistently High

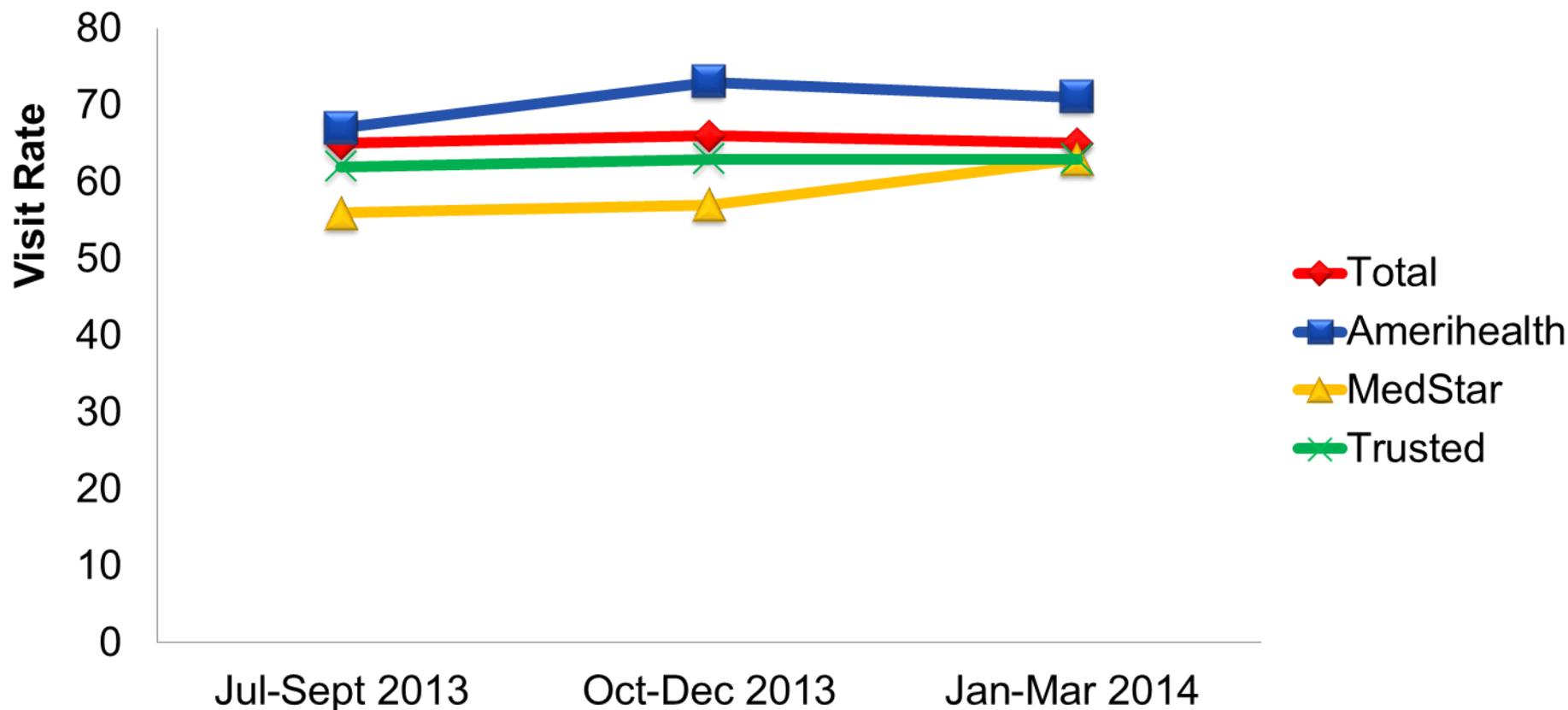
Primary Care Visit Rates For Children Who Were Enrolled In Managed Care During The Period Of January 1, 2014 Through March 31, 2014 And Had 12 Months Of Continuous Eligibility



Note: Only members who were enrolled with the health plan for three months continuously during the period of January 2014 through March 2014 and had 12 months of continuous Medicaid participation as of March 31 2014 are included in this analysis. Dates of service for primary care visit are March 2013 through March 2014.

# There Has Been No Deterioration In The “Well Child” Visit Rate

Well Child Visit Rates For Children Who Were Enrolled In Managed Care During The Period Of January 1, 2014 Through March 31, 2014 And Had 12 Months Of Continuous Eligibility



Note: Only members who were enrolled with the health plan for three months continuously during the period of January 2014 through March 2014 and had 12 months of continuous Medicaid participation as of March 31 2014 are included in this analysis. Dates of service for Well Child visits are March 2013 through March 2014.

# Much Progress Has Been Made To Integrate Children's Primary Care with Developmental, Behavioral and Oral Health Services

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- ❑ DHCF has released Transmittal 14-29 which details the new billing requirements and rate adjustments in place for EPSDT/well-child visits.
  - Effective for Fee-For-Service primary care providers October 1, 2014
  - DC EPSDT Well-Child Visit Billing Reference Guide
  - Revised EPSDT Billing Manual on Provider Portal
  - DC HealthCheck Periodicity Schedule linked to CPT Codes (available on [www.dchealthcheck.net](http://www.dchealthcheck.net))
  - Instructions for using Preventive Visit CPT codes and specific codes for screenings (e.g., 96110 for behavioral and/or developmental)

# The Billing Changes Are Critically Important To Facilitating The Program Outcomes DHCF Is Pursuing To Improve Services To Children

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- ❑ The billing changes that have been established will help DHCF and MCOs:
  - Confirm that all components of a well-child visit were performed;
  - Detail the need for diagnostic or treatment services; and
  - Establish accountability for linking and tracking children in need of EPSDT services to the appropriate providers.

# Next Steps For The Program

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- ❑ The Transmittal that specifies the billing change requirements for MCOs must be implemented by January 1, 2015
  
- ❑ Beginning in October and through November 2014, DHCF and MCOs will train primary care providers on new billing requirements
  - Training information will be posted on [www.dc-medicaid.com](http://www.dc-medicaid.com)
  
  - Well-Child visit billing changes and other primary care provider resources and information also available on-line at [www.dchealthcheck.net](http://www.dchealthcheck.net)

# Presentation Outline

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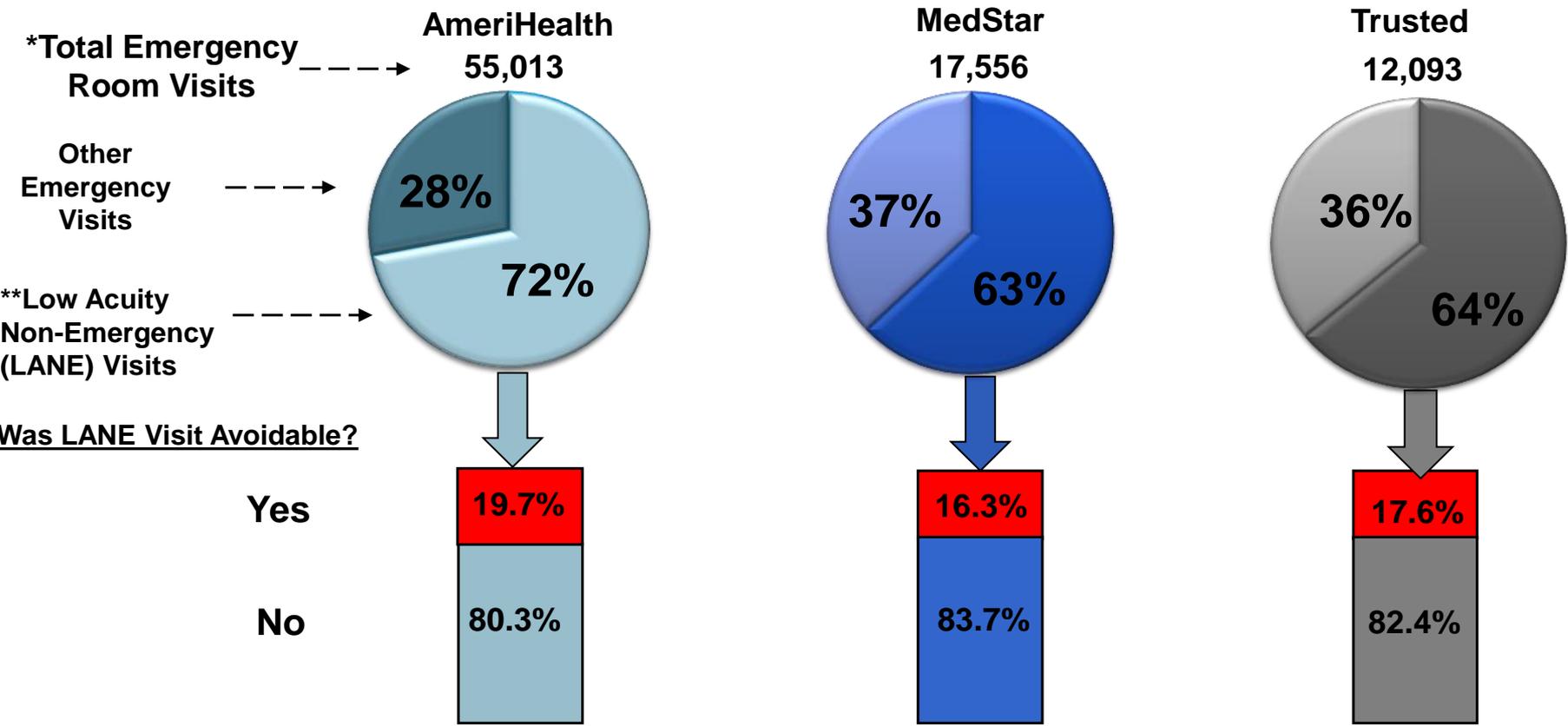
- Overview Of Managed Care And Focus of Presentation
- Summary of Key Findings
- The Financial Condition of The District's Health Plans
- The Administrative Performance Of The Health Plans
- MCO Medical Spending And Member Utilization Patterns
- Care Coordination: Goals and Outcomes**

# DHCF Relies Upon Several Metrics To Quantitatively Assess The Efforts By The Health Plans To Coordinate Beneficiary Care

- ❑ Achieving high value in health care for Medicaid and Alliance beneficiaries is a preeminent goal of DHCF's managed care program
- ❑ The District's three managed care plans are expected to increase their members' health care and improve outcomes per dollar spent through aggressive care coordination and health care management
- ❑ Sufficient time has elapsed since the contract year began in July to allow DHCF to more closely examine the following performance indicators for each of the District's three health plans:
  - Emergency room utilization for non-emergency conditions
  - Potentially preventable hospitalizations – admissions which could have been avoided with access to quality primary and preventative care
  - Hospital readmissions for problems related to the diagnosis which prompted a previous and recent – within 30 days -- hospitalization

# Across MCOs At Least Six Of 10 Emergency Room Visits Made By Plan Members Are For Low Acuity Diagnoses And Nearly Two In Ten Of These Visits Were Avoidable

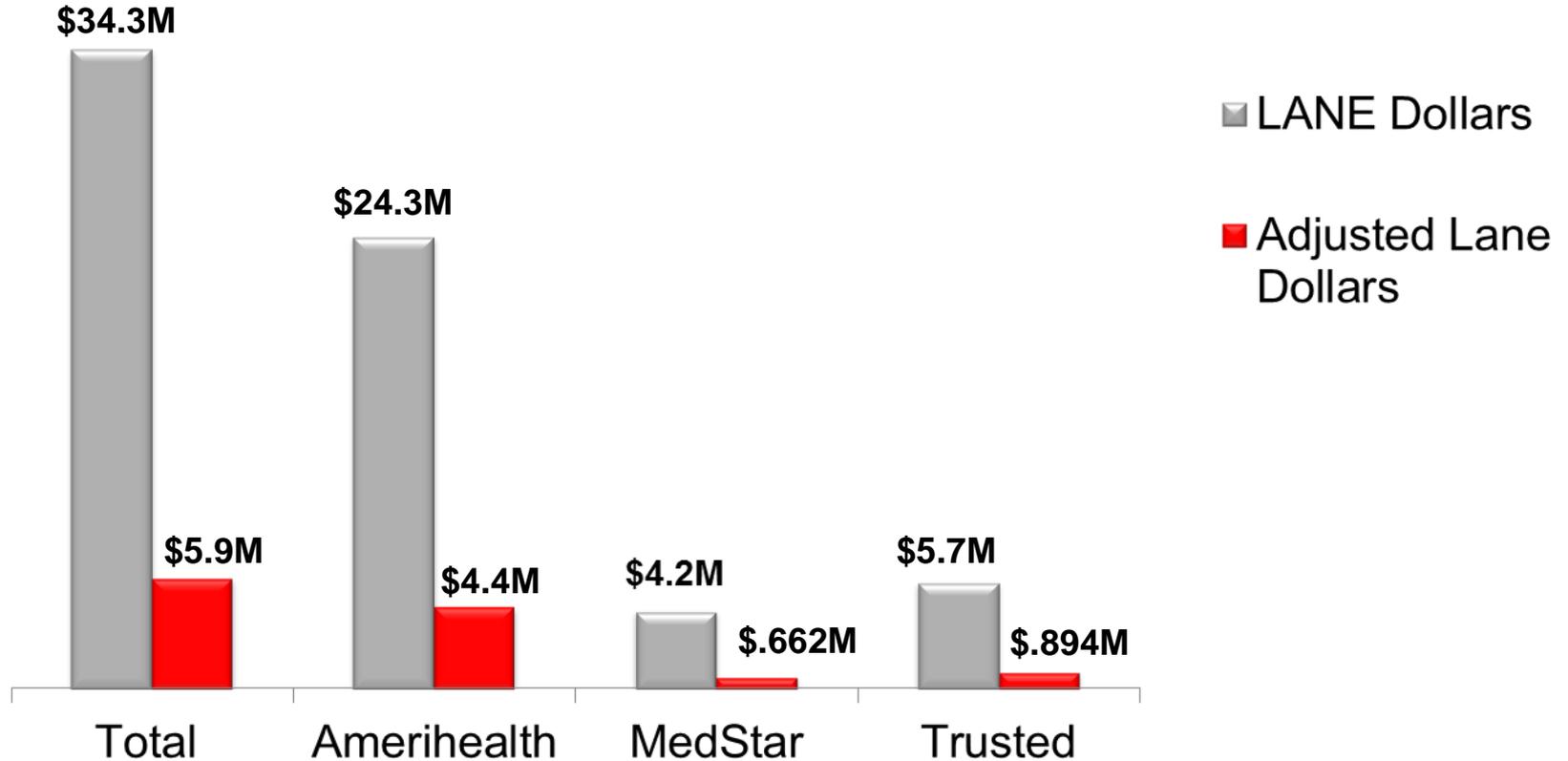
Emergency Room Utilization For Members By Level Of Acuity, July 1 2013 to March 31, 2014



\*Total emergency department visits consists of all visits to the emergency room regardless of diagnosis which did not result in an inpatient admission. \*\*Low acuity non-emergency (Lane) visits are emergency room visits that could have been avoided based on a list of diagnosis applied to outpatient data. Practicing ED physicians and Mercer clinical staff reviewed each LANE code and assigned a target utilization percentage of visits that a highly efficient managed care plan could prevent.

# The Low Acuity Avoidable Emergency Room Visits Have Cost The MCO's Almost Six Million In The First Nine Months Of The Contract Year

Cost Of Low-Acuity Visits During The Period From July 2013 through March, 2014

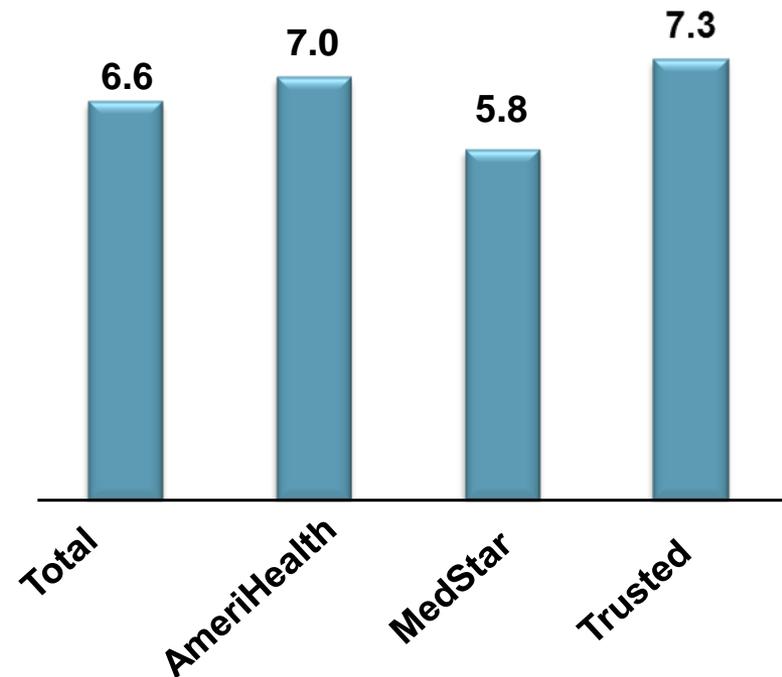


Notes: The LANE dollars are adjusted for the duration of enrollment and percent credibility factors are applied to each diagnosis based on professional judgment.

# Nearly Seven Percent Of Inpatient Hospital Admissions Are Potentially Avoidable, Costing MCOs An Additional \$5.7 Million

Potentially Avoidable Inpatient Admissions (PPA) And The Associated Cost For The Period From July 2013 Through March, 2014

Adjusted Potentially Avoidable Admissions As A Percent Of Inpatients Admits



Managed Care Plan	Cost Of PPA	Adjusted PPA Cost	Adjusted Avoidable Admits Per 1000
AmeriHealth	\$4,511,502	\$3,184,050	5.1
MedStar	\$2,698,651	\$1,774,195	7.7
Trusted	\$1,304,024	\$823,699	4.1
Total	\$8,514,177	\$5,781,945	5.5

Note: Results are based on prevention quality indicators developed by the Agency for Healthcare Research and Quality (AHRQ) that can be used with hospital discharge data to identify potentially preventable admissions for adults.

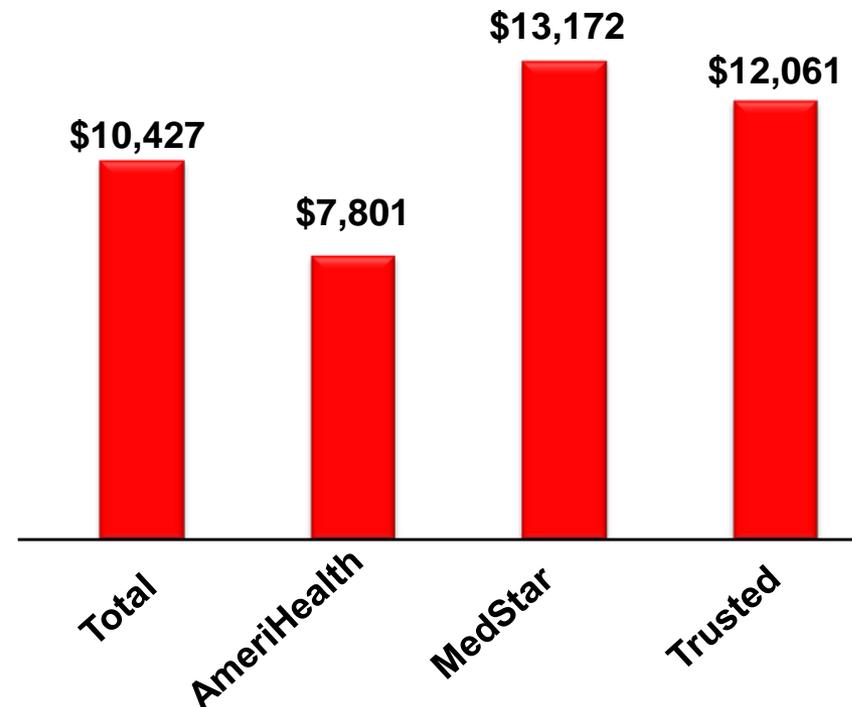
Source: MCO Encounter data provided by MCOs to DHCF.

# The Problem of Hospital Readmissions Add More Than \$10.6 Million To The MCOs Beneficiary Medical Cost

Hospital Readmissions Within 30 Days And Associated Cost For The Period From July 2013 Through March, 2014

The Cost Per Readmissions For Each Health Plan

Managed Care Plan	Ratio Of Hospital Readmissions To Index Hospital Admissions	Total Cost Of Readmissions
AmeriHealth	1 to 14.3	\$5,282,515
MedStar	1 to 11.7	\$3,319,327
Trusted	1 to 9.6	\$2,050,325
Total	1 to 12.4	\$10,652,167



Note: All-cause 30-day hospital readmissions are "hospitalizations that occur, for any reason, within 30 days of discharge from an index admission." An index admission is defined as any inpatient stay that might produce an avoidable readmission" (Mathematica, 2011). Index admissions are derived from the set of unique hospital stays, and are determined by excluding specific categories of admissions from the set of unique hospital visits such as transfer cases and deaths. Readmission rates are computed as the ratio of admissions that occur within the specified readmission time period to the number of index admissions.

# Pending Changes For The MCO Program

- ❑ Before the beginning of the next contract year DHCF either have or will execute the following changes to the MCO program:
  - Absent unanticipated budget pressures, in 2015 and each year thereafter, the start date for the MCO contracts will be moved to October 1 to coincide with the beginning of the District's fiscal year. DHCF has budgeted the necessary funds to inflate the MCO rates forward from April to October so that this change can be executed without financial losses for the health plans
  - MCO capitated rates are now risk-adjusted – MCOs with members who have the highest risk profile receive a rate enhancement. Because this policy was designed as budget neutral, any increase given to one plan will be offset by decreases for the plans with lower risk members. The risk adjusted rates will be refined in November 2015 with complete data from all three plans.
  - DHCF will implement a pay for performance system which will reduce the rates paid to MCOs that fail to meet certain performance standards. We will work with Mercer between now and October 1, 2015 to establish benchmarks for each metric that we use to measure performance. This program will only be implemented in the years that DHCF pays at least the “target rate” recommended by our actuary
  - DHCF will develop clarifying language on staffing requirements with respect to the number of case managers and other key personnel based on plan membership size while also defining allowable administrative costs. These changes will be effective October 1, 2015